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Doubly lethal: the psychological havoc of healthcare professionals during the covid-19 pandemic

Duplamente letal: a destruição psíquica dos profissionais da saúde durante a pandemia de covid-19

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This article sets out to describe and develop an analysis of how the precarization of the Unified Health System (SUS) affects the processes of subjectivation of the bodies that compose it. Using data collected from ethnographic research at an Alcohol and Drug Psychosocial Care Centre (CAPS AD) located in a municipality in the interior of São Paulo state, I explore the impacts that large-scale epidemiological events have on the mental health of the affected populations, particularly the healthcare professionals who continued to pursue their professional activities under such conditions. I first demonstrate the particularity of the covid-19 pandemic through an analysis of the political contingencies that singularize the Brazilian case within the pandemic's global context. Next, I connect macrostructuring political processes with the quotidian micropolitics of care and the affects that they mobilize. To highlight the pathways through which major changes affect individual life trajectories, I use the theoretical matrix developed by the field of the anthropology of emotions. In support of my argument, I turn to interviews and ethnographic narratives that constituted my field material during my master's degree research, initiated and completed during the covid-19 pandemic.

Precarization; SUS; CAPS AD; Pandemic.

No presente artigo busco expor e desenvolver como a precarização do Sistema Único de Saúde (SUS) afeta os processos de subjetivação daqueles corpos que o compõem. Utilizando dados colhidos a partir de uma incursão etnográfica em um Centro de Atenção Psicossocial Álcool e Drogas (CAPS AD), em um município do interior paulista, o texto que se segue se organiza por uma elaboração dos impactos que grandes eventos epidemiológicos têm sobre a saúde mental das populações que afetam, particularmente no caso dos profissionais de saúde que seguem suas práticas profissionais sob estes contextos. Ademais, viso trabalhar a particularidade da pandemia de covid-19 a partir de uma análise das contingências políticas que tornam o caso brasileiro singular dentro do contexto global da pandemia. Em um segundo momento, conecto processos políticos macroestruturantes a micropolíticas cotidianas de cuidado e os afetos que elas engajam. Para demonstrar estes caminhos pelos quais grandes mudanças afetam trajetórias individuais, utilizo a base teórica desenvolvida pelo campo da antropologia das emoções. Para sustentar a argumentação, utilizei entrevistas e narrativas etnográficas que compuseram o meu material de campo durante a vigência de meu mestrado, que se deu integralmente durante a pandemia de covid-19.

Precarização; SUS; CAPS AD; Pandemia.

Introduction

On the day I began to negotiate my entry into the **Antônio Orlando Alcohol and Drugs Psychosocial Care Centre (CAPS ADAO)[1]**, on 14 December 2020, 520 deaths from covid were recorded, adding up to a total of 181,939 deaths in Brazil at that time. On 11 January 2021, when I actually began my fieldwork, 480 people died, a total of 203,617. When my fieldwork was suspended on 16 March 2021, 2.841 deaths were recorded, an average of 1965 deaths over the last 7 days and a total of 282.400 deaths. When I completed this second period of research on 20 November 2021, 326 deaths were recorded, an average of 231 deaths over the last 7 days. And at the moment of writing this final version of this article, the number of people to have died from covid-19 in Brazil had risen to 659,000.

In total, I undertook 16 weeks of field research, divided into two 8-week segments, during which I accompanied the day-to-day life of CAPS ADAO, its workers, its *users* (*usuários*)[2] and other figures who circulated in the space: homeless people, street vendors, ambulance staff, police from the Metropolitan Civil Guard (GCM)[3] and other professionals linked to the Psychosocial Care Network (RAPS)[4].

This article is composed of ethnographic material from my master's degree research, which, when first conceived, I expected to tell the history of the Alcohol and Drugs Psychosocial Care Centres (CAPS AD), their functioning, their contingencies, their possibilities and potentialities, the legal and political context that allowed them to operate in the way they do, and the relations that pervade them. Adding to all these factors were the masks, alcohol gel, unelaborated mourning, the fear of infecting others and becoming infected. In essence, this text explores the ecologies of care (Das 2015, Das and Das 2006) and care strategies for people dependent on Psychoactive Substances (PASs) during the pandemic. Anchored in this particular historical process, I hope to describe and develop an analysis of the pathways through which the precarization of the country's principal public policy affects the processes of subjectivation of the bodies that compose it.

The notion of an "ecology of care" developed in the works of Veena Das (2015) and Veena Das and Ranendra Das (2006) produced important dialogues for my argument insofar as their formulation implies situating logics of care within local configurations, as well as revealing the complex relational networks between professionals, patients and households that function as contingencies to the course and development of sickness processes. In the case of the article by Das and Das (2006), in which they evaluate the use of medications and self-medication in poor districts of New Delhi, the causes and phenomenologies attributed to diseases and suffering are embedded in a complex local world where their meanings are entangled with work regimes, houses and distinct professional ethics, which range from the pharmaceutical industry to local medicinal therapies. It is in this amalgam of actors and agencies, meanings and significations, federal polices and local political arrangements that the ecologies of care form and inform each other. Through this theoretical configuration, it was possible to incorporate the pre-existing contingencies, as well as the drastic changes brought by the pandemic during the

1 TN: In Portuguese: Centro de Atenção Psicossocial Álcool e Drogas Antônio Orlando.

2 All the emic categories cited in this text are written in italics to emphasize the terms that I borrow from the bodies of knowledge making up the field. In the case of the category *usuário*, user, this graphic recourse is particularly important since the notion of drug *user* – written in the text without italics – is distinct from the *user* of a psychosocial service – written in italics. The category user emerges in the field of public health as a counterpoint to the notion of patient. The understanding is that naming the subject as a *user* of the public policy situates the person within a context of action, engagement, and active composition of their care process. Patient, by contrast, transmit the idea of passivity vis-à-vis the decisions taken by the distinct bodies of knowledge that compose the health area. It is a core part of the care process promoted in the CAPS AD studied by me that the person who requires the care can be an effective participant in this process.

3 TN: In Portuguese: Guarda Civil Metropolitana.

4 TN: In Portuguese: Rede de Atenção Psicossocial.

write-up of this article.

In this sense, the pandemic emerges as a fundamental contingency in the processes of constituting care networks, practices and ecologies, and consequently, also constitutes a processual event insofar as the epidemiological limits were continually negotiated in both the institutional and subjective dimensions.

Thus, care and the agents producing care at CAPS ADAO demonstrated themselves to be, respectively, the central category and central actors in my field site. As well as the care service, it was common to hear CAPS ADAO being called a "care space" among the professionals. At CAPS ADAO, when a *user* mobilizes the team, he or she is said to have "offered him/herself care".

Frequently during the period of field research, the demands of *users* who turned up at the space's doors could not be met. Recalling the pre-pandemic times, the professionals told me about occasions when the large patio in the yard of the house where CAPS ADAO was located would contain around 50 *users*. However, during the period I was with the service, use of the space was limited to 8 *users* who had been admitted to beds, plus 5 *users* for a period (morning and afternoon) in accordance with the protocol recommended by the National Health Surveillance Agency (ANVISA)[5].

Despite the reduced presence of users in the service, demands actually increased during the pandemic. At other moments, group therapy dynamics were held daily. In keeping with the principles of psychosocial methodology, the team sought to create new spaces of sociability and leisure that were not built around the use of substances. The groups were a fundamental part of the everyday work of the services and with their suspension the professionals began to hold individual consultations only. As a result, their agendas were permanently full.

The pandemic also affected the functioning of the public health network's services. Much of the work undertaken at CAPS ADAO, but also at Health Centres (CSs), Conviviality Centres (CECOs)[6] and the social care network services are based methodologically on teamwork. A professional would never manage a group alone, and this helped compose the clinical bases and Singular Therapeutic Projects (PTSs)[7] of the *users*. With the arrival of the pandemic, however, there was a continuous process of individualization of the care process.

Matrixing (*matriciamento*)[8], another fundamental practice in the constitution of care ecologies, was also suspended during the pandemic period. The exchanges between different services from the network are very important since each instrument offers a distinct type of health-related care or action. Frequently *users* had serious clinical conditions due to their constant use of alcohol – alcoholics formed the majority at CAPS ADAO. The centre was not always able to offer the clinical care needed to deal with these cases, which require on-going care. Likewise, the CSs lacked a team specialized in crisis response or that was prepared for full-time care of cases that involved the problematic use of substances.

This suspension of the *matrixings*, as well as the overload of primary care services by covid cases, meant that the same logic produced internally among the team was reproduced in the dynamic of the healthcare system itself. Services

5 TN: In Portuguese: Agência Nacional de Vigilância Sanitária.

6 TN: In Portuguese: Centros de Saúde and Centros de Convivência, respectively.

7 In Portuguese: Projetos Terapêuticos Singulares. The PTS is one of the main care strategies employed in the RAPS. Concomitantly with the notion of *user*, the PTS is a joint construct involving professionals and *users*, delimiting medium and long-term plans of action to attain objectives or resolve the demands brought by the *user* to the service. This implies that the care strategies implemented are singularized: there is no step-by-step prescribed treatment. Instead, there is a construction permanently negotiated between professionals and other professionals, professionals and users, and professionals and institutions.

8 *Matrixing* (*matriciamento*) is a practice of exchanging information on cases between the CAPS teams and the Primary Healthcare Units (*Unidades Básicas de Saúde*: UBSs). This involves regular meetings in which healthcare action and promotion strategies can be developed, vital information on cases exchanged, and resources swapped between the network's services.

ended up atomized and the exchanges between healthcare teams became rarer. At CAPS ADAO, this signified a worsening of the clinical conditions of the *users* as well as a continuous process of individualization of the processes of responsibility assumed by the professionals. The excess workload generated by the pandemic resulted in exhausted professionals and unattended *users*.

Nonetheless, this process of precarization in the possibilities for care is not something that started with the pandemic, despite worsening drastically with its advent. There is nothing new or original in asserting the precarization and dismantling of SUS as a political project (Castro, Engel and Martins 2018). For some time, we have known about the chronic queues, the lack of invested resources, structural inequalities in access to services, which are expressed in the poorest and most vulnerable areas and regions. Combined with the pandemic, this underfunding – whose initial historical landmark was Constitutional Amendment 95 – contributed to an intensification of avoidable deaths (Rutstein *et al.* 1976).

The coronavirus pandemic in Brazil marks a doubling up, a worsening, that cannot be understood as a mere continuation of what happened before. It is this disastrous management that has further intensified Brazil's structural inequalities. The covid mortality rates have reinforced the colonial logic and killed mainly black, brown and indigenous peoples, as well as informal, self-employed and underpaid workers. The vast majority of these bodies, which bear social markers of inequality, depends on the Unified Health System (SUS)[9].

9 In Portuguese: Sistema Único de Saúde.

The exhausting work of confronting the pandemic day-to-day, combined with the precarious investment in public policy, low pay, lack of materials, medications and adequate spaces for performing their work combine towards the precarization of the possibility of care, both due to the lack of basic materials and structures, and due to the consequences that this lack has on the subjective structures of the workers who execute care work.

The rest of the text is organized around a description of the impacts that major epidemiological events have on the mental health of the affected populations, particularly in the case of the healthcare professionals who continue with their professional activities under these conditions. For this purpose, I make use of interviews and ethnographic narratives that composed my fieldwork material during the course of my master's degree. In addition, I set out to explore the particularity of the covid-19 pandemic through an analysis of the political contingencies that make the Brazilian case singular within the global context of the pandemic. This aim in mind, I turn to the theoretical apparatus developed by Stengers and Pignarre (2011), especially their notion of infernal alternatives. Next, I connect macrostructuring political processes with the quotidian micropolitics of care and the affects that they mobilize. To demonstrate these pathways through which major changes affect individual life trajectories, I use the theoretical foundation developed by the field of the anthropology of emotions.

Mental health and pandemics

Large-scale epidemiological events are known to be events capable of triggering increased mental suffering for the impacted populations. The most recent example in Brazil, the 2015 Zika virus epidemic, led to an increase in diagnoses of depression, anxiety and stress among the affected population, disturbances that are closely associated with the lack of social support or the development of public policies (Kuper *et al*. 2019). During other SARS epidemics, Chinese healthcare professionals reported an increase in depression, fear, anxiety and frustration (Xiang *et al*. 2020).

In the context I was able to observe, there was also the aggravating factor of a high percentage of *users* who presented comorbidities, developed concomitantly with substance abuse. Severe cases of HIV/AIDS, tuberculosis and hepatitis are frequently encountered among people who commit abuse of substances like cocaine – in its different forms – and alcohol (Cruz *et al*. 2013, Martins 2011, Carvalho and Seibel 2009). The overloading of SUS by the covid-19 pandemic particularly worsened the states of health of these people dependent on continual follow-up care, which, in turn, made the work of the CAPS ADAO professionals especially difficult, given that they lacked the resources to perform this on-going care in a way they deemed adequate. Combined with the absence of any coherent stance by sectors of the federal government, diverse professionals were pushed, already exhausted, into a marathon of "infernal alternatives" (Stengers and Pignarre 2011) reproduced quotidianly.

The notion proposed by Pignarre and Stengers of "infernal alternatives" helps give a contour to the situations I witnessed in the field. The authors categorize infernal alternatives as "that set of situations that seem to leave no other choice than resignation or a slightly hollow sounding denunciation" (Stengers and Pignarre 2011, 24). Despite the authors' elaboration of this idea being inspired by the protests that occurred in response to the World Trade Organization (WTO) conference in Seattle in 1999, it seemed to me to be an effective instrument for thinking about how the precarization of SUS associated with the process of the pandemic had direct impacts on the provision of care at CAPS AD.

One of the fundamental points of the notion of infernal alternatives that, in my view, makes possible its transposition to such a distinct context is the fact that they are constructed, not given. As Stengers and Pignarre highlight: "the machine that produces infernal alternatives implies entire armies of specialists engaged in the ongoing creation of the conditions of its functioning" (*ibid.*, 29). Infernal alternatives and the tiredness and resignation that they imply are not a natural phenomenon, therefore, but produced by the slow erosion of public policy.

They are part of a discourse in which a certain political class seems to try constantly to convince us that nothing can be done to rid ourselves of these binds because mere opposition to them will worsen the situation. There is no possibility of introducing social isolation, or lockdowns, since that would destroy the economy – a fate even worse that the death of hundreds of thousands of Brazilians. Such

is the logic that produces infernal alternatives:

> We now find these alternatives everywhere. To adapt, to "reform" the welfare state has become an ardent obligation. Sacrifices are necessary, otherwise the financing of retirement will no longer be assured. Or social security payments will become a bottomless pit! Accepting has become an imperative (*Ibid*., 24, original italics).

The lack of clear protocols for confronting the pandemic or any centralized direction by the Ministry of Health (MS)[10] generated a perverse logic of an inversion of responsibilities between public policy and the people who construct it. The multiple forms of malaise and anguish that trouble health professionals, I argue, stem, among other things, from a subjective outsourcing of responsibilities during the pandemic.

10 TN: In Portuguese: Ministério da Saúde.

Part of the production of infernal alternatives derives from this dumping of the collective decision-making process onto individuals. In the absence of well-defined protocols for situation management, it was left to the healthcare professional to evaluate which patient should receive their attention and care. How can someone decide who dies and who lives? Which health condition is more urgent, that of an alcoholic in the initial stages of liver cirrhosis, or a HIV-positive crack user, or someone in abstinence? Or perhaps a user living on the street and under threat due to the debts owed to the drug gangs? How can a professional worker be psychologically supported in this process? These are questions to which we still lack any clear answers and merely reflecting on them can provoke nausea and anguish to anyone subject to this process.

Based on what I could observe and construe with health professionals, I understand that the microevents emergent from this context combine to shape a process that seriously threatens the subjective possibilities of existence of SUS. The myriad tales among health professionals of exhaustion, feelings of guilt, chronic tiredness, increasing burnout syndromes, depression and panic are all symptoms of this. This psychological attrition that has removed diverse professionals from the frontline is not simply a result of the pandemic but its combination with the disastrous management, in terms of lives lost, by the federal government.

During the pandemic, the exacerbation of the individualization of care continuously produced situations in which the professionals lacked sufficient resources to provide care. The combination of a care process that became more and more individual, combined with the material impossibility of providing effective care, generated feelings of tiredness and frustration among the professionals that frequently transformed into psychological fatigue.

I accompanied many exhausted professionals who ended up leaving the frontline in the attempt to save their own existence, their mental health and their presence, indispensable in the family sphere, which for a long time now has been irreconcilable with work in hospitals, health centres and analogous services. Precarization does not just apply to public structures, the medications needed to

intubate someone, and the equipment needed to maintain a human being breathing when their lungs can no longer do so unaided. During the pandemic it was also possible to say that the precarization of public policy ran hand-in-hand with a precarization of the psychological structures necessary for the provision of care and the promotion of health.

The functioning of SUS depends equally on its specialists in logistics and administration and on its frontline professionals. It depends, fundamentally, on the untiring search to amplify the borders of health governance. It depends, therefore, on sociotechnical networks and on political pacts for the latter to be effective. As emphasized earlier, these networks have undergone a process of deterioration, both following Constitutional Amendment 95 and because of the direct attacks on the care for people who abuse substances in the context of the RAPS network.

Highlighting this process that took shape over the course of the last two governments (the Temer government, 2016-2018, and the Bolsonaro government, 2018 to the present), in my view, helps us understand how the restriction of the care possibilities for substance *users* in the context of SUS constructs this universe of infernal alternatives. The virus has hit an already precarized SUS and the decision to allow it to circulate freely has attacked not only the legal and physical structures and the resources of public health, but also the flesh that sustains this vast public policy: those who work every day to make it a reality.

Many of the *users* with whom I had contact during my immersion in the field also suffered due to these impediments that the pandemic imposed on psychosocial care. As well as mental suffering and deteriorating social relations, continuous substance abuse leads to a greater propensity to develop comorbidities that are difficult to manage, especially when the presence in health services represented a risk of infection by the covid-19 virus.

As my public health interlocutors pointed out to me various times in the field, the inability to accompany clinical cases where chronic diseases were an important factor meant that these bodies became "decompensated". When I arrived at CAPS AD in the middle of January 2021, the team began to resume home visits and a close accompanying of the service's *users*. These resumed activities became possible to a large extent because the service's professionals started to be vaccinated. However, on initiating this process, the impacts of the absence of continuous accompaniment of cases where severe diseases and comorbidities were an important factor became evident.

HIV-positive cases, contracting and worsening of tuberculosis, a deterioration in the care of diabetes and liver functions due to untreated hepatitis were constant themes in the team's weekly meetings. This worsening, associated with the frequent refusal of *users* to seek out hospital care due to the stigma associated with the abject bodies of people who commit substance abuse (Rui 2012) – widely present in civil society but which is naturally also present in public healthcare institutions[11] – imposed new contingencies that made the possibility of care for these *users* profoundly difficult. Frequently, and despite the insistence of the professionals who I accompanied, this attempted care translated into an exhausted

11 For further reading, see Lancetti and his elaboration of the concept of contrafissure. In the specific case of health structures, I recommend Faria's article on the importance of *matrixing* activities in combating contrafissures within the public health system.

resignation.

To illustrate this context to which I refer, below I provide a narrative collected in the field that gives an idea of the situation and helps explain this line of argument. The case is particularly illustrative, I believe, because it is traversed by the multiple contingencies explored here so far: the worsening of comorbidities due to the impossibility of accessing hospital spaces during the pandemic; the prejudice associated with drug users, which makes their care in health services more difficult; the complete focus on the pandemic, which left these subjects to their own fate; the exhaustion and fear that emerge in these situations; and, finally, the resignation imposed by the infernal alternatives.

The account that follows describes a home visit that I conducted with a nurse and a health agent to a woman who used crack, linked to CAPS ADAO. The *user* C.C. had an extremely worrying clinical picture of associated comorbidities: HIV-positive, active tuberculosis and hepatitis C. Prior to the visit we had already learned that her health condition had worsened and reached a point where management was now difficult. In making the visit, our objective was to assess her state of health and try to persuade her to accept admission into a hospital specialized in tuberculosis located in Campos do Jordão[12]. The narrative is as follows:

12 For more information on the treatment of tuberculosis in referral centres, see Boldrim 2020.

> ***Narrative*** 8 February 2021
>
> I leave CAPS AD to make a home visit to a user of the service who is worrying the team. Reports that have reached the team from other users suggest that since the start of the pandemic, C.C. has intensified her use of crack and is now in a precarious state of health. The intensified use of crack and alcohol worsens the patient's clinical picture of comorbidities: anaemic, HIV+, Hepatitis C and active tuberculosis. This precarious picture makers it impossible for the user to be present at CAPS AD. Her precarious immunological system, if it enters into contact with SARS-COV-2, could collapse and the service lacks an adequate outpatient structure to admit her. The patient refuses to seek help from Emergency Care after multiple cases of violence that she has suffered due to the "prejudice they have for crack users," as she herself had pointed out on other occasions. Within the limited scope of care alternatives, the key professionals ended up deciding to make home visits in the attempt to persuade C.C. to get treatment. On this visit, the main concern was with the tuberculosis systems that have worsened over the last month. We left to make a weekly visit to her father's house where she lives to check the user's vital symptoms and offer the possibility of referring her to a hospital specialized in the treatment of tuberculosis in Campos do Jordão.
>
> We put on [protective gear], myself, a health agent and a nurse who are C.C.'s key professionals, and went in the car of one of the nurse's – since CAPS ADAO's vehicle was not available that day – to the home of C.C.'s father. The gate is barred and on the veranda of the small house we find C.C.,

> sat on a chair holding an apple. The clear morning light illuminates a skeletal body, evident by the shadow of the bones under C.C.'s skin. She weighed 37kg on the last medical visit that had been made a few weeks ago, and seems even thinner now. Each breath demands considerable effort, and a wheezing sound could be heard from the depths of her chest. Each step to the gate threatens a collapse of her body. The two professionals enter, chat and try to convince her once again to access Emergency Care, but unsuccessfully. The nurse calls the Health Centre to which C.C. is linked in an attempt to mobilize other professionals from the network as he checks her vital signs.
>
> "I don't know if you still have her on your books but she's going to die at home if you don't come to help!"
>
> 78 saturation. 35 respiratory movements per minute. Heart rate of 150.
>
> We call out SAMU [emergency medical care] in a last desperate attempt. During this process C.C. complains to the team, saying that she won't go to hospital under any circumstances. D. (nurse), M. (health agent) and I fall into an agitated silence. The ambulance arrives after 15 or 20 minutes. On opening the doors of the ambulance, a doctor gets out and asks us where the patient is. D., desperate, points to C.C. and says "it's her, she's desaturating [has a low blood oxygen level]!" – a claim that is immediately answered by the doctor: "I've never seen a desaturated patient eating an apple! Did you really call out SAMU for this? You must be kidding. I have a ton of people dying from covid, suffocating, and you've made me check in here?"
>
> We were left completely demoralized. The doctor and the nurse D. exchanged barbed comments. While the doctor expresses her disgust, complaining that we were in the middle of a pandemic and people are dying, C.C. slowly moves inside the ambulance. Her vital signs are not checked, and she is handed a form for her to sign confirming that she has refused care. She signs the form and the ambulance leaves.
>
> The three of us are left exchanging glances, C.C. walks back from the entrance to her house to sit where we had first found her. I return to the car with D. and M. On arriving back at CAPS AD, we don't talk as we head to the staff room. D. cries "she [the doctor] didn't even look at her [C.C.]… didn't even look…" I left CAPS AD certain that C.C. will die in the next few days.

I chose this account since it allows me to highlight the amalgamation of various factors that made it possible for C.C. not to receive care. Substance abuse and the prejudice that she had already suffered, which, combined, led to C.C. refusing hospital care. The pandemic that demanded all public health resources to be com-

batted. The indignation of the doctor over the call out of the ambulance despite the gravity of the situation. The discontinuation in the offer of care that professionals were forced to adopt due to the combination of all these contingencies.

Recalling the analysis made previously concerning the work of Stengers and Pignarre, we are left with the notion that these choices, despite taking place in everyday microrelations, possess macrostructural politics as one of their determining factors.

These political dimensions influence the construction of the world and the possibilities for action of the healthcare professionals within the available structures of SUS, as well as being expressed in the individual agencies of each actor. Along these lines, we can observe these transversalities in the refusal of the SAMU doctor to offer care taken as adequate by the nurse. The justification given by the doctor in question for refusing to collaborate with the request made by the team was not that C.C. did not need care. But rather that her case was not urgent as presumed and that they could not help due to the demands imposed by the pandemic. Had this not been the context, perhaps the outcome of this story would have been different. These are the political actions that have overloaded the public health system and impacted the individual choice to refuse care for C.C. despite the evaluation of a professional more closely involved in her case.

Comprehending how macrostructuring political movements affect the microstructured quotidian care policies of health workers is not something clearly evident. Here I follow the proposal made by Veena Das (2015) concerning the theoretical constructions through which we – anthropologists – manage to name and work with the everyday suffering that is constitutive of our fields and the lives we cross during our ethnographies.

Narratives that operate at macrostructuring levels – as in the case of the covid Parliamentary Commission of Inquiry (CPI) in Brazil's Federal Senate – or that seek to construct theories that operate at a macrostructured and generalized scale – like those I have undertaken so far through an analysis of the notion of infernal alternatives – help us understand processes that become quasi-events (Povinelli 2011) in large public scandals, processes of mediatization of the deaths caused by the virus and mobilizations of distinct affects among the general public. However, these narratives do not help us comprehend what leads a healthcare professional to surrender to the impossibility of providing care to a patient due to the lack of adequate infrastructure or even how a young woman is abandoned by the healthcare system, as we shall see later. As Veena Das reminds us:

> The juxtaposition cannot do the work of showing the pathways through which the larger changes are absorbed in individual lives. In short, the question for me comes down to whether the ethnography is meant to illustrate a theoretical argument or whether theory might be built into the ethnography itself (Das 2015, 15).

I continue my argument now by taking the proposed path. To do so, I use in-

terviews with healthcare professionals who worked during the pandemic in order to compile qualitative data that helps us understand and give meaning to the – relatively scant, it should be noted in passing – quantitative data that can be gathered on the mental health of public healthcare professionals in Brazil. I hope that this will allow a clearer understanding of how the pandemic also infected the processes of subjectivation of these professionals and the impact that this represents for the functioning of the public policy as a whole.

In the next section I seek to explain more clearly how these transversalities developed in the pandemic context and how the latter influenced the work of the healthcare professionals as well as their singular processes of subjectivation. To this end, I turn to the literature pertaining to the field of the anthropology of emotions as a means to expose the consequences and constraints that led the pandemic to affect processes of subjectivation, especially for those working in the shadow of the virus.

Anthropology of the emotions: possibilities for a transversal analysis between macropolitical dynamics and everyday suffering

While I was researching in the field, one of the main sentiments expressed daily at the centre was fear. Fear of infection by the virus, fear of transmitting the disease to a loved one or to *users* of the service, fear of being unable to obtain the resources needed to care for the *user* of the service due to the overloading of the health system with the coronavirus pandemic.

A study conducted by Fiocruz during my fieldwork period corroborates the above. On average, 87.6% of healthcare professionals felt afraid of covid at some moment of the pandemic (Lotta *et al.* 2021). The emergence of fear as an emotional tone of the life of healthcare professionals – both in primary care and in specialized and hospital care – is closely associated with an emotional and psychological load that effectively overloads health workers, something present at moments outside of work too.

The fundamental space of emergence of this mental exhaustion, however, is the body, thus overflowing into a profound physical exhaustion. Here I draw from various perspectives developed in the social sciences (Csordas 2008, Rezende and Coelho 2010) that identify the body as the main locus for supporting, processing and making possible the expression of emotions. Sadness, which very often became explicit in my field through the sight of people spilling tears and the sound of sobbing; anxiety, expressed in shortness of breath, the tired eyes of insomnia and the "stomach cramps"; and finally fear, the palpitations and unease reported by the professional staff, especially when infection was suspected.

The diverse emotions described above, the individual exhaustion that they produced, were not simply contained, however, in the distinct bodies where they emerged. A rich discussion can be found in the literature on the anthropology of emotions concerning their fundamental quality (Lutz 2011, Abu-Lughod and Lutz 1990, Coelho and Durão 2017, Coelho 2010): are emotions individual expressions

of the subject or are they culturally constituted, and do they thus possess an inherently social quality?

The field of the anthropology of the emotions developed precisely out of this debate. From the 1980s, especially in the United States, some discussions were formalized that responded to this question from what was subsequently called a "relativist perspective". The question inspiring and guiding this field of studies was comprehending how emotions possess distinct dynamics in different cultural contexts. The primary reference to be consulted along these lines is the work of Lutz (2011 [1988]) and her analysis of the Euro-American conception of the emotions and how they are constructed.

Later, however, the contextualist approach was developed, which no longer sought to understand the different significations given to emotions (through a comparative exercise) but aimed instead to discern the micropolitical dynamics that developed in the emotional field of a given group (Abu-Lughod and Lutz 1990).

> Against the backdrop of this map, Lutz and Abu-Lughod elaborate the proposal they call the contextualist perspective, theoretically inspired by Foucault's notion of discourse, understood as a speech that forms what is spoken about, rather than maintaining a relation of reference with it as something external to it. This perspective allows the authors to enter deeper into the micropolitical dimension of feelings, showing how emotions are the result of power relations between social groups, serving simultaneously to express and reinforce these relations (Coelho 2010, 268).

This theoretical construction, which largely aligns with the Foucauldian notion of discourse, infuses the analysis of emotions in the micropolitical relations that constitute the everyday. Just as the dimensions taken by the coronavirus epidemic cannot be strictly related to the properties of the virus, emotions should also be understood within a dynamic social and cultural context, which implies power relations.

The problematization that I wish to pose relates to how we can perceive the relation between the emotions – emerging in the everyday work of healthcare professionals – and the public management of the coronavirus pandemic in Brazil. I took the methodological alternative of examining the emotions provoked among healthcare professionals working in specific and difficult situations by using a contextualist approach. Although the example provided in this article is particular, this emotional micropolitics of exhaustion was also expressed by everyday activities. The following account, which I collected from a resident doctor in a hospital context, corroborates how this exhaustion was pervasive. When asked to evaluate the management of the pandemic at federal level, he emphasizes how he felt powerless in his work when watching the TV located in the "red room", where the patients with severe cases of covid were taken:

> What's your assessment of the quality of public management of the pan-

demic at federal level?

I think that with all that turbulence that we had with the swapping of ministers at the start of the pandemic [Mandetta by Teich, Teich by Pazuello], and all the measures that had been adopted by one minister being changed, and the government failing to invest directly in purchasing vaccines, not having invested in social isolation measures, it ended up that in federal terms Brazil left a lot to desire. So much so that we have already surpassed more than half a million deaths. And deaths that could have been avoided with simple measures. It left a lot to be desired.

And how did this management make you feel? Was it something you thought about while working? You mentioned these "deaths that could have been avoided," was there some situation where this struck you? What does that feel like? Was this situation incorporated in your professional work? In your everyday life?

So, sometimes we were there working, there in the red room, and we saw the president on the TV going around without a mask, the president among crowds, the president refusing to buy vaccines, and committing all these breaches that, in my view, he was committing, and **I felt angry**. Because had he been here, there was even a time when he was encouraging people to enter the hospitals to see how the patients were, you felt like saying: "come in here to see for yourself, spend some time here, so you can see the despair of these people". And many cases of patients who arrived there in a severe state, patients who, for example, had only had one vaccine dose. So, if the [vaccination] campaign had been sped up a little, they would have had their second dose and probably would not be seriously ill. So patients aged, for instance, between 40 and 50, who had received just one or no vaccine doses, previously healthy, and who came to us already severely ill, I thought "gosh, if Brazil had mobilized more money to buy more vaccines in less time, that would have led to far fewer costs to health and far fewer deaths". So, there was a huge discrepancy between what you saw on the TV, the way in which the president was acting in response to this situation, the things that were happening in the hospital. There was a huge discrepancy. A real feeling of anger, injustice, **"why am I working if the person who represents me in the country is doing the exact opposite?" There's already very little I can do, and if the federal government won't help, why am I working if I'm not going to able to solve the problem?** It's going to snowball with more and more people arriving. **The main sensation was fear, impotence.**

Here I concur with Susana Durão and Maria Claudia Coelho when they write that emotions are not a dimension of life relegated to the domain of the individual and the intimate, but are found imbricated in the relations of the world and are

conditioned by the latter to the same extent as they constitute it. I thus concur with the authors' argument that:

> Emotions, therefore, seem to do things. We act by feeling, as well as by not feeling, or by controlling the demonstrations of what we feel, or even the nature itself of what we feel. And these feelings are governed, as the anthropology of the emotions has long advocated, not by the fluctuations of the intimate, not in an idiosyncratic way, but by codified forms, permeated by moral codes and ethical-political convictions, that prescribe, evaluate, condemn, demand and even proscribe emotional reactions (Coelho and Durão 2017, 59).

I make use of this second theoretical apparatus here to comprehend the dynamics of the everyday that develop following the establishment of infernal alternatives in the context of public health. Associated with these feelings of stress, anxiety and fear, the process of decision-making and epidemiological risk calculation was very often dumped on healthcare workers in the absence of clear protocols for confronting the pandemic.

In the context that I was able to observe, there was also the aggravating factor of a high percentage of *users* who presented comorbidities, developed as a result of substance abuse. Serious conditions of HIV/AIDS, tuberculosis and different types of hepatitis are frequently encountered among people who commit abuse of substances like cocaine – in its different forms, including crack – and alcohol (Cruz, *et al*. 2013, Martins 2011, Carvalho and Seibel 2009). The remarks below, taken from the same interview cited previously, show how these conditions of comorbidities, which have a high incidence among the population assisted by the CAPS AD, suffered a process of "decompensation" over the course of the pandemic.

> Yes, there were a lot of changes, since many of the activities not related to covid were cancelled, so many outpatient services were cancelled. So what happened, like, we had an outpatient clinic for patients with diabetes. So staff provided teleguidance, phoned people, asked whether everything was okay, and if they were fine, they would reschedule appointments for a later time. **This meant that patients received less care and would come to us increasingly decompensated. So chronic diseases became increasingly decompensated because they were receiving less medical care.** So, we had less contacts with these people, more limited contacts, always using equipment and protect, so that somewhat hinders the doctor-patient relationship. […] It was very difficult to follow-up on patients closely, which was something we should have done, but there was no way to do so, we had to reschedule the outpatients to avoid infections, there was no alternative.

The complete focus of the public health system on the pandemic was a burden that affected both the professionals and its users. The overwhelming of the SUS by

the covid-19 pandemic both worsened the state of health of those dependent on constant accompaniment and attacked the processes of subjectivation of health workers. Combined with the absence of positioning by sectors of the federal government, diverse professionals were pushed, already exhausted, into a marathon of infernal alternatives that were reproduced quotidianly.

Here I highlight one final quotation before concluding the text. I had the chance to record this dialogue in a public meeting concerning the mental health council from the municipality where I conducted fieldwork. The meeting, held in March 2021, sought to address a number of urgent questions, both political and epidemiological, relating to the maintenance and functioning of the municipal RAPS during the pandemic. A manager from the RAPS health service made an analysis that seemed to me profoundly assertive in terms of the possibilities of existence of psychosocial care in SUS in the political and epidemiological context that I have sought to describe in this article.

> The pandemic thing is so hard and has had direct effects on the issue of mental health. There has been a worsening of mental worse, the worsening of the pandemic, primary care having to be focused entirely on this issue, hence the mental suffering, everything relating to mental health, much has ended up in a limbo. I think all of this is going to reverberate a lot within the service. How primary case at this moment has become organised in relation to these subjective forms of suffering and how we deal with this. CAPS (where I work) suspended face-to-face matrixings [*matriciamentos*], though it maintained group care. Now things are much more serious, including from the economic and social viewpoint, **people are dying of covid, or dying of hunger, or dying of violence. Then added to that we have this threat from a government that uses the context of the pandemic to dismantle what already existed, what was already being scrapped. We have to be more solidary as a network, if not we won't survive, much less the users of the service** (Field notebook, 19/03/2021).

Conclusion

The mental and physical exhaustion described by healthcare professionals during the period of the pandemic has as a consequence, beyond the destruction of the possibilities of resistance of healthcare professionals, the depletion of the health system itself. SUS depends on the political machine and on funding to the same extent that it depends on the workers who give it body. The first of these factors already found itself under attack prior to the pandemic. The second, under the shadow of infernal alternatives, now suffocates both from the virus and from the lack of air caused by panic attacks and anxiety crises.

The infernal choices described by Stengers and Pignarre have their roots in the very dynamics of neoliberalism. We might think it strange to mobilize these

sources in the context of a public and universal policy and in the infernal choices that emerge from within it. Yet if we recall, this was precisely the justification given by the federal government for resisting the practices of social isolation at the beginning of this regime of brutality.

We also saw how the feelings of disdain over deaths from the pandemic expressed by the federal government had a direct impact on the micropolitical everyday of the emotions of healthcare workers, a factor that should be included in the reckoning of the psychological havoc inflicted on these professionals during the pandemic context.

Not an enemy but allied to the Bolsonaro government's agenda, the virus became doubly lethal: lethal to the lungs, yes, but also lethal to the psychological structures of those whose work is to maintain the ecologies of care that set out from SUS.

To these questions we can add others prior to the emergence of the pandemic. Social markers of gender, race and class flesh out this multiple body that is under attack: mostly female, black and poor. In this context, the possibilities shrink for actions that do not translate into a "resignation or a slightly hollow sounding denunciation" (Stengers and Pignarre 2011, 24). Faced by this political negligence over the pandemic and the lack of protocols for managing and controlling the situation, Brazil already has a tally of more than half a million deaths. But not only. The subjective possibilities for the existence of SUS are also being killed.

Foucault showed how the management of leprosy and plague were fundamentally processual events insofar as it was through them that strategies were developed for managing bodies, as well as sweeping changes in the ways that power is expressed. While leprosy was managed simply through measures for containing and excluding the sick bodies, the plague invented the forms of disciplinary management and excluding inclusion: the segmentation of urban space, the creation of boundaries, zones of control.

This same plague management technique was applied in much of the western world as a prophylactic measure against the covid pandemic, but we can also already perceive new techniques for managing these problems, emphasizing the processual character of the covid pandemic, at least with regard to the forms of control and power, the management of populations and biopolitics. The experiences of Japan, South Korea, Taiwan and Israel already indicate a new management based on pharmacopornographic techniques of biosurveillance (Preciado 2020) through the individual tracking of sick people via their mobile phones[13].

What we have seen here in relation to care for people who abuse PASs and the particular difficulties of implementing this care in the context of the pandemic in Brazil is the extent to which the management of the drug dispositif (Fiore 2020) entails an overlap of the techniques created on the basis of these experiences as a whole. The mass incarceration that developed from the war on drugs and the exclusion of peripheral populations by their association with drugs – whether their consumption or trafficking – are expressions of a necropolitical logic of exclusion. The segregation techniques to which people circulating on the street are submit-

13 The notion of pharmacopornographic techniques of biosurveillance developed by Preciado indicates a "type of management and production of the body and of sexual subjectivity" within a new political configuration where body and subjectivity are regulated, beyond the disciplinary institutions, also and principally "by a set of biomolecular, microprosthetic, digital and information transmission technologies". Preciado writes that "if I call them pornographic it is because, firstly, these techniques of biosurveillance introduce themselves into the body, traversing the skin, penetrating us; and, secondly, because the dispositifs of biocontrol no longer function through the repression of sexuality (masturbatory or not) but through the incitement to the constant consumption and production of a regulated and quantifiable pleasure. The more we consume and the healthier we are, the better controlled we become" (Preciado 2020).

ted under the pretext of health and hygiene, impressed in our subjectivities, are dispositifs that we have inherited from the management of the plague.

The population accompanied by CAPS ADAO, therefore, find themselves under permanent scrutiny of both these logics and squeezed between these forces, which frequently prevents their bodies from being taken as worthy of attention and care. The ethnographic dialogues and narratives that give body to this article are a portrait of this process, still highly preliminary, of attempting to adapt to the new biopolitical and pharmapornographic forms of management of biosurveillance.

Nevertheless, in the folds of this still incomplete process, we can find other tools of care, the principal example of which is the permanent attempt to amplify the ecologies of care (Das 2015, Das and Das 2006). In this sense, the pandemic extrapolates its macrostructuring processual dimension and seeps into the everyday microstructured life processes of the bodies that we accompany, as well as profoundly altering the mesorelational care projects that were previously articulated through matrixing.

During the pandemic, whenever a user indicated respiratory symptoms during their stay in a bed at CAPS ADAO, the only solution possible was to forward them to a shelter for symptomatic patients, organised by the Campinas municipal government. Two emergency shelters were organised for the homeless population with flu-like symptoms, which combined had the capacity to hold 80 people.[14] Despite being part of the public health network, the Campinas RAPS did not have covid tests to evaluate people case-by-case. Consequently, when flu-like symptoms were perceived by the user or the health workers, the person was sent to these shelters.

These new management instruments for covid cases comprised ecologies of care (Das 2015, Das and Das 2006) and the latter have not ceased to exist despite the new pharmapornographic forms of biosurveillance of bodies (Preciado 2020). Equally, the central role of the professionals in the articulation, construction and maintenance of these ecologies, whether articulating family members of the users, medicinal alliances or institutional partnerships, formal or informal, is reiterated in contexts like that of the pandemic and reiterate the multiple processes that permeate the particularity of this historical moment.

What stands out, therefore, is the fact that the possibilities of existence of care remain, despite the multiple attacks made on public policies. The relational and political networks of affect mobilized from and also beyond SUS continue to be developed despite the material and concrete weakening of public policy.

It becomes clear, however, how this abandonment affects the subjective care processes. Techniques and resources are becoming ever scarcer and, consequently, there is a worsening of the vulnerability of the populations assisted by these instruments. This, in turn, weakens the pre-existing ecologies of care, something reflected in the professionals through feelings of frustration and fatigue[15].[16]

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